Is there an appropriate framework for examining UK pharmacy practice?

In this article, health economist **Darrin Baines** outlines a conceptual framework designed to identify how environment, institutions, organisations and philosophy all influence the ways in pharmacy services are provided

Recently I argued that, following the implementation of the new contract, community pharmacists may face the prospect of wide-ranging organisational reforms.[1] Although the contract will promote the provision of essential and advanced services, the new remuneration systems may fail to secure the Government's long-term objective of fully integrating pharmacy and other primary care services.[2] Consequently, the next 15 years may become a period of rapid and ongoing transformation of the ways in which NHS pharmaceutical services are funded, organised and delivered.

In this paper I will outline a conceptual framework designed to identify how environment, institutions, organisations and philosophy all influence the ways in which pharmacy services are provided. At its core, this framework is based upon a recent renaissance in thinking about institutions (and organisations) within the social sciences labelled "new institutionalism".

Applied to pharmacy, this approach suggests that "institutions", such as the Medicines Act 1968, specify the rules of the "game" that pharmacists must play in order to generate revenue from the NHS. If the idea of pharmacy as a game is widely adopted, thinking in pharmacy could move beyond the current concern with new contract implementation, and begin concentrating on the best way to approach the reforms ahead. Indeed, a new way of seeing could reduce the profession's obsession with extending professional roles and start concentrating minds on the important issue of how to integrate pharmacy services with the rest of the NHS.

Hierarchy of influences

Within the pharmaceutical industry, it is common to talk about the health care "environment" when planning marketing strategies for the NHS. The concept of environment is simply shorthand for a range of factors that influence the provision of patient services, including Government policy and levels of public funding. As Figure 1 shows, environmental factors may be seen as the lowest level in a hierarchy of influences on pharmacy practice, while Panel 1 gives real examples of these categories.

At the next stage, the "institutional framework" specifies the rules that define the "game" pharmacists must play against the background of an ever-changing NHS environment.[3] Indeed, the Nobel Prize winning economist, Douglas North, defined "institutions" as "the rules of the game in a society" or, more formally, as "the humanly devised constraints that shape human interaction".[4]

Figure 1: Hierarchy of influences on pharmacy practice

Panel 1: Influences on pharmacy practice

- **Practice** Skill-mix, electronic transfer of prescriptions, medicines use reviews, repeat dispensing
- **Philosophy** Traditional practice model, pharmaceutical care, medicines management, new apothecary model
- **Organisation** local pharmaceutical services sites, medicines management projects, health centre pharmacies, patient group directions
- **Institutional frame** Medicines Act, Royal Pharmaceutical Society ethical guidance, control of entry regulations, Health and Social Care Act
- **Environmental factors** Public funding, NHS policy, UK and EU medicines policy, demand for over-the-counter sales

Next in our hierarchy, "organisations" emerge as the players of these rules, which North defines as "groups of individuals bound by some common purpose to achieve objectives". In the current context, independent and multiple pharmacies may be seen as separate groups of players organised to work for the objective of generating revenue by supplying government-funded medicines. Since the second and the third layers of the hierarchy can be compared to the playing of a game, it may be hypothesised that these players will strive to win by a combination of skills, strategy and co-ordination. Since rules can be broken, primary care trusts and the Royal Pharmaceutical Society can be seen as organisations policing the behaviour of community pharmacists competing for the rewards that the NHS offers.

At this level, the notion of philosophy enters our analysis because players adopt philosophies that outline and guide their tactics for survival, while the policing authorities have their own philosophies of control.

Traditionally, pharmacies adopted Jacob Bell's philosophy of education, professionalism and professional fraternity when running their businesses, as this promised higher levels of more stable income.[5] Today, many independents and shareholders in large pharmacy chains are driven by a belief in profits rather than the fellowship of pharmacists, with the result that their philosophy for playing the pharmacy game differs.

In response, medicines management has been vigorously promoted as a new professional value system designed to counteract the urge to make money, while the Society's code of ethics strives to do the same in a different way.

Finally in this hierarchy, the way in which pharmacy is practised is, itself, an influence on pharmacy practice, with choices about such factors as appropriate skill-mix affecting the ways in which pharmacists behave.

Sociological analysis

The study of institutions has revolutionised the way in which some economists perform their analyses, and the same could happen among pharmacy practice academics.

To date, sociology has been the main social science discipline to shape and influence the ways in which pharmacy practice academics think in the UK. Although traditional sociological analysis yields many useful insights into the operation of community pharmacy, the strict adherence to this academic perspective limits the ways in which the world is seen by the profession.

With its roots in the thinking of the 1960s and 1970s, the form of sociological analysis learnt by the current breed of pharmacy academics emphasises:

- Pharmacy as a "profession"
- Pharmacists as "actors" of a "professional role"
- Professional roles as "boundaries and constraints"

A classic example of this world view is the important paper by Holloway *et al* written on the subject of reprofessionalisation, which argued for extended professional roles for NHS-funded pharmacists.[6] Because their minds were influenced by this type of analy-

sis many pharmacy academics (and the politicians and the practitioners they trained) view changes in policy as primarily designed to redefine professional roles. For instance, medicines management is seen by many pharmacy educators as an opportunity to widen the clinical tasks performed by appropriately qualified pharmacists.

In response, mainstream training courses focus on extending basic clinical skills around medicines usage, with little attention being paid to important management issues such as the rationing of drugs. Similarly, the new contract (with its introduction of medicines use reviews) is being hailed by many as an opportunity to reprofessionalise the pharmacy workforce, with scant focus on organisational imperatives such as prioritising care.[7]

Although seemingly critical, the argument outlined here is not opposed to the traditional forms of sociological thinking favoured by pharmacy practice academics, but simply suggests an extension to their analytical toolkit. Indeed, much of the current theorising about institutions and organisations performed by modern economists has its roots in the work of leading sociologists such as Durkheim and Weber.

However, recent years have seen the birth of "new institutionalism".[8] In response, greater effort should now be expended on developing theories that further our understanding of how environmental, institutional, organisational and philosophical influences affect pharmacy practice.

Once a new institutional perspective is adopted, pharmacy academics, politicians and practitioners may gain a richer insight into the game that the profession must now play.

American example

Even though some academics love theorising for its own sake, an applied discipline like pharmacy practice must be aware of the usefulness of the models its practitioners create Let me, therefore, use the example of the American health care system to illustrate the ways in which the framework outlined in Figure 1 can be used.[9] For simplicity, only one feature has been included in each section in Panel 2, which outlines the primary features of managed care pharmacy in the US.

For instance, an insurance-based approach to providing both private and public care has been determined to be the predominant feature of the US health care environment. Similarly, the institutions of American law and the structure of managed care companies dominate the ways in which pharmacy and other services are provided to US residents. Pharmaceutical care, a favoured academic import in the UK, is a predominant feature of "managed care pharmacy", ie, pharmacy services provided by managed care organisations.[10] Finally, controls on pharmaceutical usage, such as drug utilisation reviews (DURs), strictly control the ways in which pharmacy is practised.

Although these features of the US system are a simplification of reality, they allow us to perform our comparative analysis. First, it must be noted that managed care (and managed care pharmacy) evolved out of a situation peculiar to the US, in which the belief that health benefits should reflect individual financial contributions is enshrined in law. In contrast, the NHS was founded upon the principle of "equal access for equal need", with the 1946 NHS Act dictating that local pharmacy services must be organised in a way that facilitates the collection of all medicines prescribed by general practitioners. Consequently, "spatial equity" (ie, equality measured in terms of the distance between patients and pharmacists) became the guiding principle for the design of UK community pharmacy.

Given the institutionalisation of spatial equity, community pharmacy evolved differently in the UK from the US, with the former concentrating on guaranteeing supply and the latter focusing on controlling demand. As a result, different organisational structures began to emerge. And, out of necessity, pharmaceutical care developed as an alternative to the traditional model of pharmacy practice suggested by Jacob Bell because conditions were different in the US.

Only by understanding that it was born in a particular environment, with incumbent institutions and organisations, will champions of this concept in the UK realise that this idea was not meant to travel. Indeed, pharmaceutical care is like baseball or American football in the sense that it is best played at home.

Panel 2: Primary features of US managed care pharmacy

- **Practice** Usage controls
- **Philosophy** Pharmaceutical care
- **Organisation** Managed care structures
- **Institutional frame** US law
- **Environmental factors** Insurance-based

Way ahead

Last year I and a colleague argued that the new contract not only changed the remuneration system for community pharmacists in England, but altered the institution they work within.[3]

Here, this argument has been developed, and a new conceptual framework for analysing the working of NHS pharmacy has been outlined based upon the insights of new institutionalism.

Within an environment controlled by factors such as government policy and funding, institutions specify the rules that define the game that pharmacists must play. In response, pharmacists act as players who organise themselves for the purpose of generating revenue by supplying government-funded medicines.

With PCTs and the Society policing their behaviour, these players strive for success by employing a combination of skills, strategy and co-ordination, which could commonly be called their "commercial strategy".

In contrast to the idea of pharmacists as professional actors, the "new institutional" approach outlined here suggests that we should see:

- Pharmacy as a "game"
- Pharmacists as "players" with a "commercial strategy"
- Commercial strategies bounded by "professional constraints"

By adopting these beliefs, the enthusiasm for seeing pharmacy reforms as extending the clinical roles available to the profession should be dampened, and a more fitting, institutional view of things promoted. For instance, training for the new contract could steer away from its emphasis on developing new clinical skills, and concentrate more on strategic issues such as the ways in which medicines should be rationed. Indeed, this could be beneficial because many pharmacists are now finding themselves with new skills, but are unsure how to use them to maximise the security and profitability of their activities in the longer term.

If this new thinking is adopted, pharmacists could be taught effective strategies for employing their skills using frameworks such the "theory of moves", which outlines appropriate tactics in game situations.[11]

In conclusion, therefore, it may be argued that, for community pharmacy to develop beyond its immediate concern with new contract implementation, efforts must be made to think differently about the current reforms.

If this judgement is correct, then it is recommended that adopting the new institutional idea of pharmacy as a game, with pharmacists as its players, may be a useful way ahead.

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